

2024 Measure Set Review (MSR): Final Preliminary Assessment

The following information was sourced in June of 2024 from the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), discussions with CMS program leads, and publicly available CMS datasets (see links below).

I. Measure Information

CMIT ID	Title
00004-01-C-PCHQR	30-Day Unplanned Readmissions for Cancer Patients
Measure Steward	CMS Program
Seattle Cancer Care Alliance	Prospective Payment System-Exempt Cancer Hospital Quality Reporting

Measure Overview
<p>Rationale: For many cancer patients, readmission following hospitalization may be preventable and should be addressed to potentially lower costs and improve patient outcomes. The Alliance of Dedicated Cancer Centers, or ADCC (an organization of the 11 National Cancer Institute-designated comprehensive cancer centers that are exempt from the Prospective Payment System), recognizes the need for oncology-specific efficiency measures, including unplanned readmissions, because planned readmissions are often used in clinical pathways for cancer patients. CMS adopted this measure for the PCHQR measure set beginning with FY 2021 program year data (83 FR 41613 through 41616). After consideration of public comments, CMS finalized proposed to begin public display of this measure beginning with FY 2024 program year data (87 FR 49313).</p>
<p>Description: 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as fee-for-service Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of emergency or urgent.</p>
<p>Numerator: The numerator includes all eligible unplanned readmissions to any short-term acute care hospital defined as admission to a PPS-Exempt Cancer Hospital (PCH), a short-term acute care Prospective Payment (PPS) hospital, or Critical Access Hospital (CAH) within 30 days of the discharge date from an index admission that is included in the measure denominator. Readmissions with an admission type (UB-04 Uniform Bill Locator 14) of emergency = 1 or urgent = 2 are considered unplanned readmissions within this measure.</p> <p>Exclusions: Readmissions for patients with progression of disease (using a principal diagnosis of metastatic disease as a proxy) and for patients with planned admissions for treatment (defined as a principal diagnosis of chemotherapy or radiation therapy).</p>
<p>Denominator: The denominator includes inpatient admissions for all adult fee-for-service Medicare beneficiaries where the patient is discharged from a short-term acute care hospital (PCH, short-term acute care PPS hospital, or CAH) with a principal or secondary diagnosis (i.e., not admitting diagnosis) of malignant cancer within the defined measurement period.</p> <p>Exclusions: The following index admissions are excluded from the measure denominator: 1) Less than 18 years of age; 2) Patients who died during the index admission; 3) Patients discharged against medical advice (AMA); 4) Patients transferred to another acute care hospital</p>

during the index admission; 5) Patients discharged with a planned readmission; 6) Patients having missing or incomplete data; and, 7) Patients not admitted to an inpatient bed.	
Measure type: Outcome	Measure is a composite: No Measure is digital and/or an eCQM: No
Level(s) of analysis/measured entity: Facility/Hospital/Agency	Care setting: Hospital: Inpatient Acute Care Facility
Risk adjustment and/or stratification: No	Data source: Claims Data
Data collection method: Review of claims data	Reporting frequency: Once a year based on performance period. Publicly reported annually in October – available PDC only: <ul style="list-style-type: none"> - FY 2025: October 1, 2022-September 30, 2023 - FY 2026: October 1, 2023-September 30, 2024
All required data are collected as part of clinical workflow: Yes	Reporting overlap with similar/related measures: None within PCHQR.
Does this measure fill a statutorily required category for the program? No	Is this measure included in upcoming rulemaking? No

Measure Status	
Current CBE Endorsement Status: Endorsed	CBE Endorsement History: Initial Endorsement: 2017.

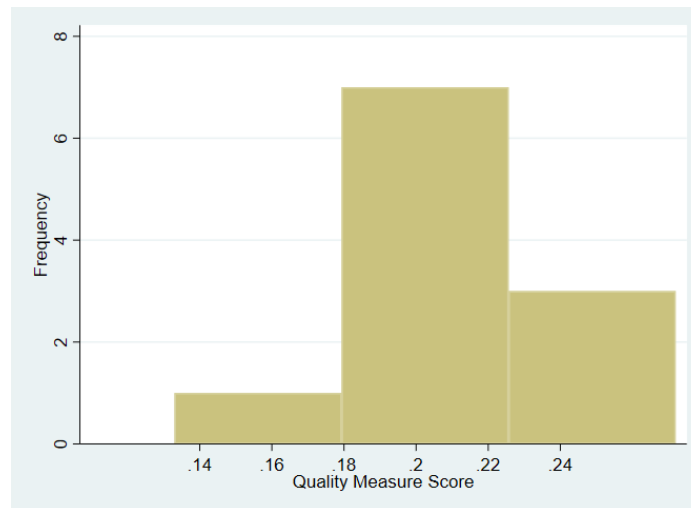
II. Measure Performance

00004-01-C-PCHQR Performance in 2022

For this measure, the MSR evaluation and analysis team reviewed the publicly available dataset [Unplanned Hospital Visits - PPS-Exempt Cancer Hospital – Hospital](#) and [archived Hospital](#) data.

A histogram of performance score is shown in Figure 1. This is a quick view of the distribution of the scores across all entities. Data was only available for this measure for Performance Year 2022.

Figure 1. Histogram of Measure Score in 2022



Importance Table

Interpretation of measure scores: This table shows the relative spread of the scores and how many patients are impacted. Often the lowest or highest deciles (which, by definition, each represent 10% of the entities) may represent a disproportionately higher or lower percentage of patients. If the lowest decile contains only 5% of the patients for example, it suggests that low patient population may be related to low scores. The table can also be used to evaluate the impact of improving the score. It is common practice to use the performance of the top 20% of the entities as a benchmark. Here, 20% of the entities perform better than the 3rd Decile (20.5), which could be considered the benchmark. The number of adverse events for each decile can be estimated by multiplying the total patients by the corresponding rate. Here the estimated total number of adverse events across all deciles is 4,171. If Deciles 4-10 performed at the benchmark of 20.5, there would be an estimated 132 (3%) fewer adverse events (about 4,039).

Table 1. Importance (Decile by measure score, 2022)

Data Type	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Score (SD)	20.98 (3.38)	13.3	16.0	19.6	20.5	20.9	21.5	21.6	21.9	22.7	23	27.2	27.2
Entities	11	1	2	1	1	1	1	1	1	1	1	1	1
Total Patients	19,986	712	945	1,682	6,385	4,590	2,139	356	1,057	588	2,141	103	103

Reliability Tables

Two tables are used to summarize reliability. For Table 2, entities are sorted by patient volume, and the average reliability is reported along with the number of entities and average number and total patients for each decile. These tables can be used to assess the impact of population size on the reliability of an entity’s measure score. In cases where reliability has a strong relationship to population size, reliability will be the lowest at Decile 1 and progressively increase up to Decile 10.

For Table 3, entities are sorted by reliability, and the average reliability by decile is reported. Average, standard deviation, minimum and maximum reliability, and inter-quartile range (IQR) are also included. This table can be used to see the distribution of the reliability of the entities. A measure score is generally considered reliable when the reliability for at least 70% of the individual entities is above 60%.

Table 2. Reliability (Decile by denominator – target population size)

Data Type	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Target Population Size	1,817	103	168	356	588	712	1,057	1,682	2,139	2,141	4,590	6,385	6,385
Mean Reliability	71.3	21.6	33.3	52.7	64.0	76.6	76.6	85.0	87.0	86.5	93.6	95.4	95.4
Entities	11	1	2	1	1	1	1	1	1	1	1	1	1
Total Patients	19,986	103	336	356	588	712	1,057	1,682	2,139	2,141	4,590	6,385	6,385

Table 3. Mean reliability (By reliability decile)

Mean	SD	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max	IQR
71.3	23.2	21.6	33.3	52.7	64.0	76.6	76.6	85.0	86.5	87.0	93.6	95.4	95.4	34.3

Interpretation: Reliability was estimated using the Adams¹ signal-to-noise method. Of all entities, 91% have a reliability greater than 60%, indicating that this measure may be effective in differentiating entities by quality of performance.

¹ Adams, John L., *The Reliability of Provider Profiling: A Tutorial*. Santa Monica, CA: RAND Corporation, 2009.